STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaint IN00093566. Complaint IN00093566 - Substantiated. A State Residential deficiency related to the allegation is cited at R0241. Survey date: August 1, 2011 Facility number: 001142 Provider number: 001142 AIM number: N/A Survey team: Barbara Gray, RN Census bed type: Residential: 19 Census payor type: Other: 19 Total: 19 Sample: 3 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on August 3, 2011 by Bev Faulkner, RN	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to administer medications according to the physician's order and failed to obtain a physician's order to hold medications for 1 of 3 residents sampled for medications. (Resident #A) Findings include: Resident A's record was	R0241	1. Within five minutes of discovering that Resident A had received the wrong medications, LPN#1 faxed that information to the resident's physician and contacted the family. The physician instructed LPN#1 to monitor the resident's blood pressure and vital signs QID for 48 hours. Resident A was monitored QID for 48 hours with no negative results. The monitoring and results were entered into the resident's medical record. In regard to LPN #1's failure to obtain a physician order to withhold Resident A's ordered medications, LPN #1 resumed passing Resident A's medication at the next scheduled med pass.2. All residents have the potential to be effected by a med pass error. The current method used by this facility has been in place for many years without error. On August 4, 2011, the Administrator performed a one-on-one inservice with LPN#1, reviewing the cause of the medication error, policies and procedures regarding medication passes and the requirement of obtaining physician orders in order to hold medications.3. An	09/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed on 8/1/11 at 10:42 A.M. Diagnoses included but were not limited to hypertension, atrial fibrillation (irregular heart rhythm), aseptic necrosis of both hips, ischemic necrosis right femur, irritable bowel syndrome, gastroesophageal reflux disease, depression, and anxiety. A July, 2011, physician's recapitulation order for Resident #A indicated the following orders: 1.) Fentanyl 100 microgram (mcg) patch		all-nursing inservice regarding the same topics reviewed with LPN#1 will be held by the Adminsitrator on August 17, 2011. Also, at the time of the medication count at the end of each shift the incoming nurse will complete a medication count form to demonstrate that the counts were correct or that there were discrepancies in the count. If a discrepancy occurs, it must be accounted for by the outgoing nurse with a detailed explanation. A copy of each medication count will be provided to the Administrator for a period of four (4) consecutive weeks. All discrepancies will be discussed by the Administrator and the nurses involved in the count.4. The Administrator will be responsible for monitoring the results of all medication counts for the four (4) week period, and will randomly review subsequent counts.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(pain medication). 1 patch topically, changed every other day with 25 mcg patch to = 125 mcg. 2.) Fentanyl 25 mcg/hr patch. 1 patch topically, changed every other day with 100 mcg patch to = 125 mcg. 3.) Lisinopril 10 milligram (mg) - 1 tablet by mouth daily at 8:00 A.M. for high blood pressure. 4.) Metamucil - mix 15 milliliters (ml) with liquid and take by mouth daily at 8:00 A.M. (fiber laxative). 5.) Venlafaxine capsule ER - 150 mg daily at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8:00 A.M. (anti-depressant) 6.) Vitamin E capsule - 400 units - take 2 capsules by mouth daily at 8:00 A.M. 7.) Digoxin 0.125 mg tablet by mouth daily at 8:00 A.M. - check pulse. (cardiac medication) 8.) Calcium with vitamin D 600 mg - take 1 tablet by mouth 2 times a day at 8:00 A.M., and 5:00 P.M. 9.) Colace 100 mg capsule - take 1 capsule 2 times a day at 8:00 A.M., and 5:00 P.M. (stool softener)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nurses notes for Resident #A indicated the following: "7/12/11 at 9:10 A.M. - I was passing my A.M., medications that I had set up in the medication room, along with other residents' medications. All medications were set up with med cards in the tray with a list of medications the residents take. I grabbed the cup of medications I thought were Resident #A's and gave them to her. Then I went back into the medication room to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	finish my other medication passes and realized Resident #A's medications were still in the tray. I realized I had given Resident #A the wrong medications." A fax message to the physician for Resident #A dated 7/12/11 at 9:15 A.M., indicated the following: "I gave Resident #A another resident's medications. They were Aspirin 81 mg, diltiazem 180 mg [cardiovascular medication], potassium chloride 20 meq, Celexa			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10 mg [anti-depressant], Centrum Silver tablet, Avapro 300 mg [anti-hypertensive], HCTZ 25 mg [diuretic-antihypertensive], Vitamin D 1,000 units, and oyster shell calcium with vitamin D 500 mg. What do I need to watch for?" A return fax message from the physicians office indicated the following response. "Monitor the patient's blood pressure and vital signs QID (4 times a day) for 48 hours."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview with LPN #1 on 8/1/11 at 11:18 A.M., indicated she set up her morning medication pass on 7/12/11, in a tray with a medication card behind each resident's medication, listing the medications each resident should receive. LPN # 1 indicated she was not sure how Resident #A received another resident's medication. LPN #1 indicated she must have been hurrying when she gave Resident #A another resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications. An interview with LPN #1 on 8/1/11 at 4:42 P.M., indicated she held all of Resident #A's 8:00 A.M., medications on 7/12/11, except Resident #A's two Fentanyl patches and her Metamucil. LPN #1 indicated she began dispensing Resident #A routine scheduled medications again at her 12 noon medication pass. LPN #1 indicated she did not receive an order to hold Resident #A's 8:00 A.M., medications.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	LPN #1 indicated she did not receive any clarification on what medications should be held or resumed for Resident #A, after receiving another resident's medication on 7/12/11. LPN #1 indicated she made the choice on her own to hold most of Resident #A's routine 8:00 A.M., medications. LPN # 1 indicated she should have obtained a physician's clarification to hold or administer Resident #A's medications on 7/12/11,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	after giving Resident #A another resident's medications. LPN #1 was observed for a medication pass on 8/1/11 at 12:20 P.M. Two cups of medications containing two medications each were set up in cups on a tray. The medication cups had a card behind each cup with each resident's name, room number, physician's name, name of the medications the resident was to receive, and the time the medications were due.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Two medicine cups of applesauce were also on the tray. LPN #1 took the tray of medications to the dining room, placed the medications in the applesauce one at a time, and handed both residents their medications one at a time. Both residents took the medications, dipped the medications out of the applesauce with a spoon, and took their medications without any problems. LPN #1 was observed for medication pass on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/1/11 at 1:58 P.M. LPN #2 set up six residents' medications in cups and placed them in a tray. The medication cups had a card behind each cup with each resident's name, room number, physician's name, the name of the medications the resident was to receive, and the time the medications were due. Six cups of water and one small medicine cup with applesauce were set on the tray. LPN #1 carried the tray to each resident's room and dispensed each resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	their medication off of the tray. All six residents took their medications without any problems. An interview with LPN #1 on 8/1/11 at 2:30 P.M., indicated the facility had used this medication pass procedure since she had worked at the facility. LPN #1 indicated she had worked at the facility for 14 years. This state residential finding relates to Complaint IN00093566.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE